		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005405

Facility Name: HILLTOP CONVALESCENT CENTER

Address: 910 WEST POLK (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: (217) 345-7006 **Fax #** (217) 345-6017

IDPA ID Number: 3707766700001

Date of Initial License for Current Owners: 07/01/58

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/00 to 07/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,629	18	2,421	4,068	8
9	SNF/PED					9
10	ICF	10,174	5,989		16,163	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,803	6,007	2,421	20,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.32%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/01/58

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 2,421

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 07/31/01 Fiscal Year: 07/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 **Report Period Beginning:** 08/01/00 **Ending:** 07/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	72,132	8,235	3,198	83,565		83,565		83,565			1
2	Food Purchase		55,017		55,017		55,017	(995)	54,022			2
3	Housekeeping	27,230	7,635		34,865		34,865		34,865			3
4	Laundry	13,770	5,038		18,808		18,808		18,808			4
5	Heat and Other Utilities			63,393	63,393		63,393		63,393			5
6	Maintenance	14,259	12,180	19,574	46,013		46,013	535	46,548			6
7	Other (specify):* **Utility Workers**	3,283			3,283		3,283		3,283			7
8	**TOTAL General Services**	130,674	88,105	86,165	304,944		304,944	(460)	304,484			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	528,600	66,562	2,273	597,435	(56,096)	541,339	1,069	542,408			10
10a	Therapy	16,303	468	125,780	142,551	(125,780)	16,771		16,771			10a
11	Activities	28,146	1,273		29,419		29,419		29,419			11
12	Social Services			1,875	1,875		1,875		1,875			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	573,049	68,303	141,928	783,280	(181,876)	601,404	1,069	602,473			16
	C. General Administration											
17	Administrative	52,175		8,016	60,191	1,575	61,766	24,218	85,984			17
18	Directors Fees											18
19	Professional Services			164,401	164,401		164,401	(157,964)	6,437			19
20	Dues, Fees, Subscriptions & Promotions			5,901	5,901		5,901	(2,763)	3,138			20
21	Clerical & General Office Expenses	20,546	5,531	4,739	30,816		30,816	12,110	42,926			21
22	Employee Benefits & Payroll Taxes			123,823	123,823		123,823	7,677	131,500			22
23	Inservice Training & Education			337	337		337	36	373			23
24	Travel and Seminar			1,894	1,894	(1,813)	81	876	957			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,365	64,365		64,365	278	64,643			26
27	Other (specify):*			10,899	10,899		10,899	(10,899)				27
28	**TOTAL General Administration**	72,721	5,531	384,375	462,627	(238)	462,389	(126,431)	335,958			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	776,444	161,939	612,468	1,550,851	(182,114)	1,368,737	(125,822)	1,242,915			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,904	15,904		15,904	4,946	20,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			35,544	35,544		35,544		35,544			33
34	Rent-Facility & Grounds							2,860	2,860			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			51,448	51,448		51,448	7,806	59,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					182,114	182,114		182,114			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			59,130	59,130	182,114	241,244		241,244			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	776,444	161,939	723,046	1,661,429		1,661,429	(118,016)	1,543,413			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,676	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(369)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,533)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,935)	27		24
25	Fund Raising, Advertising and Promotional	(2,805)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,431)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING	(995)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,392)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(106,624)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (106,624)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,016)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy	X		125,780	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		1,015	10	42
43	Prescription Drugs	X		43,308	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule OXYGEN	X		8,692	10	45
46	Other-Attach Schedule Med Sup&IV	X		3,319	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 182,114		47

STATE OF ILLINOIS

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 08/01/00

Ending: 07/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	393	0	0	0	0	0	0	0	0	0	393	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(158,043)	0	0	0	0	0	0	0	0	0	(158,043)	19
20	Fees, Subscriptions & Promotions	(2,805)	0	0	0	0	0	0	0	0	0	0	(2,805)	20
21	Clerical & General Office Expenses	(369)	0	0	0	0	0	0	0	0	0	0	(369)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(393)	0	0	0	0	0	0	0	0	0	(393)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,899)	0	0	0	0	0	0	0	0	0	0	(10,899)	27
28	**TOTAL General Administration**	(14,073)	(158,043)	0	0	0	0	0	0	0	0	0	(172,116)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,073)	(158,043)	0	0	0	0	0	0	0	0	0	(172,116)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 **Report Period Beginning:** 08/01/00 **Ending:** 07/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,676	0	0	0	0	0	0	0	0	0	0	3,676	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,676	0	0	0	0	0	0	0	0	0	0	3,676	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,397)	(158,043)	0	0	0	0	0	0	0	0	0	(168,440)	45

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		D'ADRIAN CONVALESCENT CENTER	GODFREY	Nrsg Home Mngrs	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	78.18	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE			
DANA KLEIN	4.24	MEADOW MANOR	TAYLORVILLE			
PHILIP KLEIN	4.24	MENARD CONVALESCENT CENTER	PETERSBURG			
LISA K. GILDAR	4.24	SUNRISE MANOR OF VIRDEN	VIRDEN			
DAVID & RAQUEL KLEIN	4.55					
JERRY & PAULA JENNINGS	4.55					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 164,203	NURSING HOME MANAGERS, INC	39.39%	$	$ (164,203)	1
2	V	VAR	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC	39.39%	51,419	51,419	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC - DIRECT ALLOCATION		6,160	6,160	3
4	V	24	TRAVEL	393	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(393)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		393	393	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 164,596			$ 57,972	$ * (106,624)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					$ 9,871	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	78.18					1,387	17-7	2
3	SAM KLEIN	PRESIDENT	MANAGEMENT	0.00					1,387	17-7	3
4											4
5											5
6		Jerry Jennings, Sam Klein, and H. Raymond Klein were paid by Nursing Home Managers, Inc.									6
7		a related organization. Total compensation of $10,010 for each Sam Klein and H. Raymond Klein was									7
8		allocated among the six related nursing homes. Based upon 10 hours per week for Sam Klein and									8
9		10 hours per week for H. Raymond Klein. For Jerry Jennings $71,252 of compensation was									9
10		allocated among the related homes based upon 35 hours per week.									10
11											11
12											12
13								TOTAL	$ 12,645		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	37,411	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,852	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,559)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	38,103	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	35,544	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	35,532	8
	1997	38,484	9
	1998	35,146	10
	1999	34,533	11
	2000	35,172	12

LINE 2: 2ND INSTALLEMENT 1999	$17,266	LINE 4: 2ND INSTALLMENT 2000	$17,586	
1ST INSTALLMENT 2000	17,586	7/12 OF 35,172	20,517	
	$34,852		$38,103	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLTOP CONVALESCENT CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0005405

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-00706-000	HILLTOP NURSING HOME	$ 35,171.56	$ 35,171.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,171.56	$ 35,171.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 5,295	1
2					2
3	TOTALS			$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1966		$ 253,434	$	30	$	$	$ 253,434	4
5	36			1972	240,043	2,470	30		(2,470)	240,043	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	2,877		10			2,877	9
10	LANDSCAPING			1980	1,417		5			1,417	10
11	IMPROVEMENT			1979	17,131		15			17,131	11
12	IMPROVEMENT			1981	4,330		VAR			4,330	12
13	IMPROVEMENT			1982	3,570		15			3,570	13
14	IMPROVEMENT			1983	3,583		15			3,583	14
15	IMPROVEMENT			1984	2,461		15			2,461	15
16	IMPROVEMENT			1985	14,201	789	15		(789)	14,201	16
17	AIR CONDITIONER			1986	1,620	84	10		(84)	1,620	17
18	CONDENSOR			1986	3,068	160	15	96	(64)	3,068	18
19	ROOF			1986	19,843	1,032	15	1,211	179	19,843	19
20	CUBICAL TRACKS			1987	997	32	20	50	18	750	20
21	AIR CONDITIONER			1987	1,149	36	10		(36)	1,149	21
22	AIR CONDITIONER			1988	3,145	100	10		(100)	3,145	22
23	WATER HEATER			1988	982	31	15	66	35	857	23
24	WATER HEATER			1989	2,194	70	15	146	76	1,703	24
25	AIR CONDITIONER			1991	1,959	62	10	162	100	1,959	25
26	SIDEWALK			1991	3,120	99	20	156	57	1,664	26
27	WIRING			1992	1,384	44	20	69	25	679	27
28	AIR CONDITIONER			1992	1,474	47	10	148	101	1,336	28
29	DOOR ALARM, FURNACE, IMPROVEMENT			1993	6,664	211	15	444	233	3,774	29
30	LANDSCAPING			1993	2,824	188	10	283	95	2,398	30
31	BLACKTOP - PER 1991 AUDIT			1990	2,186		15	146	146	1,168	31
32	AIR CONDITIONER			1994	1,613	41	10	161	120	1,154	32
33	LIGHTING			1995	2,729	70	10	273	203	1,774	33
34	AIR CONDITIONER			1996	1,112	28	8	139	111	707	34
35	EXHAUST FAN, FLOORING, WATER HEATERS			1996	5,048	129	15	336	207	1,852	35
36	REMODELING - WALLS			1996	1,080	28	30	36	8	180	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1996	$ 1,611	$ 41	15	$ 108	$ 67	$ 501	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	1,517	38
39	AIR CONDITIONERS	1999	3,185	82	10	319	237	825	39
40	ROOF	1999	68,332	1,752	20	3,417	1,665	7,403	40
41	FURNACE	2000	1,273	33	15	85	52	156	41
42	AIR CONDITIONERS	2001	1,404	35	10	140	105	140	42
43	GAZEBO	2001	1,374	28	15	76	48	76	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 695,131	$ 7,997		$ 8,424	$ 427	$ 604,445	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 130,147	$ 7,803	$ 11,097	$ 3,294	Various	$ 70,918	71
72	Current Year Purchases	2,901	104	59	(45)	Various	59	72
73	Fully Depreciated Assets	152,050					152,050	73
74	Assets No Longer in Service	(58,078)					(58,078)	74
75	TOTALS	$ 227,020	$ 7,907	$ 11,156	$ 3,249		$ 164,949	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 927,446	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,904	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,580	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,676	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 769,394	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 5	hrs	$	1,101	$	46,320	$	1,101	$ 46,320	1
2	Licensed Speech and Language Development Therapist	39 - 5	hrs		144		4,193		144	4,193	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 5	hrs		1,819		75,267		1,819	75,267	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 5	# of prescrpts					43,308		43,308	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab,IV,Supplies,Oygen	39 - 5						13,026		13,026	13
14	TOTAL			$	3,064	$	125,780	$ 56,334	3,064	$ 182,114	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 07/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 172,183	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	190,151		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,722		6
7	Other Prepaid Expenses	52,581		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 435,637	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	79,149		12
13	Land	5,295		13
14	Buildings, at Historical Cost	692,945		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	283,529		16
17	Accumulated Depreciation (book methods)	(843,654)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 217,264	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 652,901	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,660	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,746		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,314		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,103		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,431		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 164,254	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 164,254	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 488,647	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 652,901	$	48

*(See instructions.)

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 503,920	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 503,920	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	481,827	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(497,100)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (15,273)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 488,647	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,052,531	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,052,531	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	39,951	6
7	Oxygen	13,270	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,221	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,012	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,012	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,136	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING $995 ADMIT FEE $360 W/A $9	1,364	28
28a	B.D. RECOV. $6523 GAIN ON INVEST. $21469	27,992	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,356	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,143,256	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	304,944	31
32	Health Care	783,280	32
33	General Administration	462,627	33
	B. Capital Expense		
34	Ownership	51,448	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,661,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	481,827	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 481,827	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,720	1,812	$ 33,122	$ 18.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,116	5,262	82,475	15.67	3
4	Licensed Practical Nurses	9,921	10,046	111,507	11.10	4
5	Nurse Aides & Orderlies	31,969	32,774	301,496	9.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,716	1,748	16,303	9.33	8
9	Activity Director	1,867	2,021	16,928	8.38	9
10	Activity Assistants	1,959	2,018	11,218	5.56	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,098	2,194	21,857	9.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,753	8,179	50,275	6.15	15
16	Dishwashers					16
17	Maintenance Workers	2,183	2,203	14,259	6.47	17
18	Housekeepers	4,700	4,763	27,230	5.72	18
19	Laundry	2,367	2,422	13,770	5.69	19
20	Administrator	2,000	2,080	52,175	25.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,036	2,132	20,546	9.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	583	619	3,283	5.30	33
34	TOTAL (lines 1 - 33)	77,988	80,273	$ 776,444 *	$ 9.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 3,198	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	56	1,673	10 - 3	38
39	Pharmacist Consultant	48	600	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	35	1,875	12 - 3	45
46	Other(specify)				46
47	Administrative Consultant	300	8,016	17 - 3	47
48					48
49	TOTAL (lines 35 - 48)	676	$ 27,362		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	0	$ 0		53

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ARACELI HENSON	ADMINISTRATOR	0	$ 52,175
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,175

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 8,016
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 8,016

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 164,203
C S C	CORP. REPRESENTATION	198
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 164,401

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,185
Unemployment Compensation Insurance	6,336
FICA Taxes	57,899
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CHRISTMAS PARTY	263
EMPLOYEE LIFE INSURANCE	1,595
GIFT CERTIFICATES	1,020
EMPLOYEE CAFETERIA PLAN	16,525
NURSING HOME MANAGERS ALLOCATION	7,677
TOTAL (agree to Schedule V, line 22, col.8)	$ 131,500

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
CHRISTMAS PARTY	22	$ 263
GIFT CERTIFICATES	22	1,020
TOTAL		$ 1,283

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,097
Health Care Worker Background Check	696
(Indicate # of checks performed 58)	
PUBLIC RELATIONS	2,805
FRANCHISE FEE	103
NURSING HOME MANAGERS ALLOC.	42
Less: Public Relations Expense	(2,805)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,138

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISCELLANEOUS MILEAGE REIMB.	81
Seminar Expense	
NURSING HOME MANAGERS ALLOC.	1,269
LESS 31% OF NHM TRAVEL	
TRANSFERRED TO LINE 17	(393)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 957

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/00 Ending: 07/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT	9/90	$ 1,925	3 YR	$	$	$	$	$	$	$	$	$
2	DECORATION	7/93	1,884	3 YR									
3	PAINT & WALLCOVER	7/94	3,986	3 YR									
4	PAINT & WALLPAPER	7/96	3,825	3 YR	1,275	637							
5	PAINT & WALLPAPER	3/97	5,058	3 YR	1,686	1,686	843						
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,678		$ 2,961	$ 2,323	$ 843	$	$	$	$	$	$

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/00 **Ending:** 07/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **72** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V PAGES 3 & 4

OTHER GENERAL ADMINISTRATION - LINE 27

BAD DEBT	$	1,935
SALES TAX		1,533
ILLINOIS RT TAX		7,431
	$	10,899

DETAIL OF RECLASSIFICATIONS - COLUMN 5

			LINE #
RECLASS FROM:			
OXYGEN	$	(8,692)	10
MEDICARE DRUGS		(43,308)	10
MEDICARE SUPPLIES		(1,873)	10
MEDICARE LAB FEES		(1,015)	10
MEDICARE IV'S		(1,446)	10
PHYSICAL THERAPY		(75,267)	10A
SPEECH THERAPY		(4,193)	10A
OCCUPATIONAL THERAPY		(46,320)	10A
RECLASS TO: ANCILLARY	$	182,114	39
RECLASS TO:			
NURSE CONSULTANT MILEAGE	$	238	10
ADMINISTRATIVE CONS. MILEAGE		1,575	17
RECLASS FROM: TRAVEL	$	(1,813)	24

SCHEDULE XVII - PAGE 19
RECONCILIATION OF INCOME

NET INCOME - LINE 43	$	481,827
*MANAGEMENT FEE 7/31/00		(14,012)
*MANAGEMENT FEE 7/31/01		20,836
RENTAL INCOME PASSED DIRECTLY TO SHAREHOLDERS		(21,469)
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS		(7,136)
TAXABLE INCOME	$	460,046

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

SCHEDULE XI - PAGE 13 - SECTION E
RECONCILIATION OF DEPRECIATION

LINE 83	$	19,580
NURSING HOME MANAGERS ALLOCATION		1,270
SCHEDULE V - LINE 30 - COLUMN 8	$	20,850

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS.

PAGE 6 SCHEDULE VII B LINE 2
NURSING HOME MANAGERS COSTS

CENTRAL OFFICE COST ALLOCATION
HILLTOP
2000

	AUG 00	SEPT	OCT	NOV	DEC	JAN 01	FEB	MARCH	APRIL	MAY	JUNE	JULY	2000 TOTAL	LINE
SALARIES-ADMIN	$1,547	$1,577	$1,549	$1,473	$1,443	$1,997	$2,019	$1,892	$1,859	$1,972	$1,884	$1,839	$21,051	17
SALARIES-CLERIC	816	832	817	777	761	1,054	1,065	998	981	1,040	994	970	11,105	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	0	0	0	0	0	159	160	150	148	156	150	146	1,069	10
ACCOUNTING	7	7	7	7	7	6	6	6	6	6	6	6	79	19
WORK COMP INS	19	20	19	18	18	20	21	19	19	20	19	19	232	22
SUPPLIES	30	30	30	28	28	79	80	75	74	78	75	73	679	21
TELEPHONE	76	77	76	72	71	48	49	46	45	47	45	44	695	21
EMPL BENEFITS	408	416	409	389	381	386	391	366	360	381	365	356	4,606	22
PAYROLL TAXES	220	224	220	210	205	261	264	247	243	258	246	240	2,839	22
TRAVEL	173	176	173	165	161	62	63	59	58	62	59	57	1,269	24
IN SERVICE	3	3	3	3	3	3	3	3	3	3	3	3	36	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	0	0	0	0	0	13	13	12	12	13	12	12	86	6
OWNERS COMP	248	253	248	236	231	231	234	219	215	228	218	213	2,774	17
INS-PROP,LIAB,WC	23	24	23	22	22	24	25	23	23	24	23	22	278	26
DEPRECIATION	112	114	112	107	104	107	108	101	100	106	101	98	1,270	30
RENT	248	253	248	236	231	244	247	231	227	241	230	224	2,860	34
MAINTENANCE	38	38	38	36	35	39	40	37	37	39	37	36	449	6
FEES & PUBLICAT	4	4	4	4	3	4	4	3	3	3	3	3	42	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$3,972	$4,049	$3,976	$3,783	$3,704	$4,738	$4,790	$4,487	$4,411	$4,677	$4,470	$4,362	$51,419	
FIXED ASSETS													51,419	
EQUIP - PRIOR	6,715	6,845	6,721	6,394	6,261	8,910	9,009	8,439	8,295	8,796	8,407	8,203	7,750	
EQUIP - CURR	3,091	3,152	3,094	2,944	2,883	0	0	0	205	218	208	203	1,333	
EQUIP - FULLY DEP	821	837	822	782	766	1,277	1,291	1,210	1,189	1,261	1,205	1,176	1,053	
BLDG - PRIOR	984	1,003	985	937	917	943	953	893	878	931	890	868	932	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

HILLTOP CONVALESCENT CENTER # 0005405 08/01/00 TO 07/31/01 PAGE27
MONTHLY COSTS ALLOCATIONS ON PAGE 26

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SALARIES-ADMIN	$1,915	$1,547	$1,994	$2,158	$1,291	$1,674	$10,578
SALARIES-CLERIC	1,010	816	1,052	1,138	681	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	6	8	50
WORK COMP INS	24	19	25	27	16	21	132
SUPPLIES	37	30	38	42	25	32	204
TELEPHONE	94	76	98	106	63	82	518
EMPL BENEFITS	505	408	526	569	341	442	2,791
PAYROLL TAXES	272	220	284	307	184	238	1,505
TRAVEL	214	173	223	241	144	187	1,183
IN SERVICE	4	3	4	5	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	319	346	207	268	1,694
INS-PROP,LIAB,WC	29	23	30	32	19	25	158
DEPRECIATION	139	112	144	156	93	121	765
RENT	307	248	320	346	207	268	1,696
MAINTENANCE	46	38	48	52	31	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,917	$3,972	$5,120	$5,540	$3,314	$4,298	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,311	6,715	8,655	9,364	5,602	7,265	45,912
EQUIP - CURR	3,826	3,091	3,985	4,311	2,579	3,345	21,138
EQUIP - FULLY DEP	1,016	821	1,058	1,145	685	888	5,614
BLDG - PRIOR	1,217	984	1,268	1,372	821	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
SALARIES-ADMIN	$1,906	$1,577	$1,915	$2,092	$1,415	$1,673	$10,578
SALARIES-CLERIC	1,005	832	1,011	1,104	747	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	7	8	50
WORK COMP INS	24	20	24	26	18	21	132
SUPPLIES	37	30	37	40	27	32	204
TELEPHONE	93	77	94	102	69	82	518
EMPL BENEFITS	503	416	505	552	373	441	2,791
PAYROLL TAXES	271	224	273	298	201	238	1,505
TRAVEL	213	176	214	234	158	187	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	305	253	307	335	227	268	1,694
INS-PROP,LIAB,WC	28	24	29	31	21	25	158
DEPRECIATION	138	114	139	151	102	121	765
RENT	306	253	307	335	227	268	1,696
MAINTENANCE	46	38	46	51	34	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,893	$4,049	$4,918	$5,371	$3,633	$4,296	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,272	6,845	8,314	9,078	6,141	7,262	45,912
EQUIP - CURR	3,808	3,152	3,828	4,180	2,828	3,343	21,138
EQUIP - FULLY DEP	1,011	837	1,017	1,110	751	888	5,614
BLDG - PRIOR	1,212	1,003	1,218	1,330	900	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
SALARIES-ADMIN	$1,919	$1,549	$1,916	$1,993	$1,507	$1,695	$10,578
SALARIES-CLERIC	1,012	817	1,011	1,052	795	894	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	7	8	50
WORK COMP INS	24	19	24	25	19	21	132
SUPPLIES	37	30	37	38	29	33	204
TELEPHONE	94	76	94	98	74	83	518
EMPL BENEFITS	506	409	506	526	398	447	2,791
PAYROLL TAXES	273	220	273	284	214	241	1,505
TRAVEL	215	173	214	223	169	190	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	307	319	241	271	1,694
INS-PROP,LIAB,WC	29	23	29	30	23	25	158
DEPRECIATION	139	112	139	144	109	123	765
RENT	308	248	307	320	242	272	1,696
MAINTENANCE	47	38	46	48	37	41	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,927	$3,976	$4,920	$5,117	$3,869	$4,351	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,328	6,721	8,317	8,651	6,540	7,355	45,912
EQUIP - CURR	3,834	3,094	3,829	3,983	3,011	3,386	21,138
EQUIP - FULLY DEP	1,018	822	1,017	1,058	800	899	5,614
BLDG - PRIOR	1,220	985	1,218	1,267	958	1,077	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
SALARIES-ADMIN	$2,012	$1,473	$1,925	$1,921	$1,486	$1,761	$10,578
SALARIES-CLERIC	1,062	777	1,016	1,013	784	929	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	10	7	9	9	7	8	50
WORK COMP INS	25	18	24	24	19	22	132
SUPPLIES	39	28	37	37	29	34	204
TELEPHONE	98	72	94	94	73	86	518
EMPL BENEFITS	531	389	508	507	392	465	2,791
PAYROLL TAXES	286	210	274	273	211	251	1,505
TRAVEL	225	165	215	215	166	197	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	322	236	308	308	238	282	1,694
INS-PROP,LIAB,WC	30	22	29	29	22	26	158
DEPRECIATION	146	107	139	139	107	127	765
RENT	323	236	309	308	238	282	1,696
MAINTENANCE	49	36	47	47	36	43	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,167	$3,783	$4,943	$4,932	$3,814	$4,521	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,734	6,394	8,356	8,337	6,448	7,642	45,912
EQUIP - CURR	4,021	2,944	3,847	3,838	2,968	3,519	21,138
EQUIP - FULLY DEP	1,068	782	1,022	1,019	788	934	5,614
BLDG - PRIOR	1,279	937	1,224	1,221	944	1,119	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%
SALARIES-ADMIN	$1,972	$1,443	$1,916	$1,986	$1,431	$1,831	$10,578
SALARIES-CLERIC	1,041	761	1,011	1,048	755	966	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	7	9	50
WORK COMP INS	25	18	24	25	18	23	132
SUPPLIES	38	28	37	38	28	35	204
TELEPHONE	97	71	94	97	70	90	518
EMPL BENEFITS	520	381	505	524	377	483	2,791
PAYROLL TAXES	281	205	273	283	204	261	1,505
TRAVEL	221	161	214	222	160	205	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	316	231	307	318	229	293	1,694
INS-PROP,LIAB,WC	29	22	29	30	21	27	158
DEPRECIATION	143	104	139	144	104	133	765
RENT	316	231	307	318	229	294	1,696
MAINTENANCE	48	35	46	48	35	44	257
FEES & PUBLIC	5	3	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,064	$3,704	$4,918	$5,099	$3,673	$4,702	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,560	6,261	8,314	8,620	6,209	7,948	45,912
EQUIP - CURR	3,941	2,883	3,828	3,969	2,859	3,659	21,138
EQUIP - FULLY DEP	1,047	766	1,017	1,054	759	972	5,614
BLDG - PRIOR	1,254	917	1,218	1,263	909	1,164	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
SALARIES-ADMIN	$2,679	$1,997	$2,512	$2,617	$2,001	$2,439	$14,245
SALARIES-CLERIC	1,413	1,054	1,325	1,381	1,055	1,287	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	213	159	199	208	159	194	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	20	26	27	20	25	$145
SUPPLIES	106	79	99	104	79	97	$564
TELEPHONE	64	48	60	63	48	59	$343
EMPL BENEFITS	518	386	486	506	387	472	$2,756
PAYROLL TAXES	350	261	328	342	261	319	$1,861
TRAVEL	84	62	79	82	63	76	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	16	17	13	16	$91
OWNERS COMP	310	231	291	303	232	283	$1,650
INS-PROP,LIAB,WC	33	24	31	32	24	30	$174
DEPRECIATION	144	107	135	140	107	131	$763
RENT	327	244	307	319	244	298	$1,739
MAINTENANCE	53	39	49	51	39	48	$280
FEES & PUBLIC	5	4	4	5	4	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,356	$4,738	$5,960	$6,208	$4,746	$5,787	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,953	8,910	11,208	11,675	8,925	10,883	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,714	1,277	1,607	1,674	1,280	1,560	9,111
BLDG - PRIOR	1,265	943	1,186	1,235	944	1,152	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
SALARIES-ADMIN	$2,701	$2,019	$2,658	$2,477	$1,978	$2,412	$14,245
SALARIES-CLERIC	1,425	1,065	1,402	1,307	1,044	1,272	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	214	160	211	197	157	191	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	21	27	25	20	25	$145
SUPPLIES	107	80	105	98	78	95	$564
TELEPHONE	65	49	64	60	48	58	$343
EMPL BENEFITS	522	391	514	479	383	466	$2,756
PAYROLL TAXES	353	264	347	324	258	315	$1,861
TRAVEL	84	63	83	77	62	75	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	17	16	13	15	$91
OWNERS COMP	313	234	308	287	229	279	$1,650
INS-PROP,LIAB,WC	33	25	32	30	24	29	$174
DEPRECIATION	145	108	142	133	106	129	$763
RENT	330	247	325	302	241	294	$1,739
MAINTENANCE	53	40	52	49	39	47	$280
FEES & PUBLIC	5	4	5	4	3	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,407	$4,790	$6,307	$5,876	$4,693	$5,721	$33,794
FIXED ASSETS							
EQUIP - PRIOR	12,050	9,009	11,860	11,051	8,825	10,759	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,727	1,291	1,700	1,584	1,265	1,542	9,111
BLDG - PRIOR	1,275	953	1,255	1,169	934	1,138	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
SALARIES-ADMIN	$2,601	$1,892	$2,683	$2,471	$1,896	$2,703	$14,245
SALARIES-CLERIC	1,372	998	1,416	1,303	1,000	1,426	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	150	213	196	151	215	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	27	25	19	27	$145
SUPPLIES	103	75	106	98	75	107	$564
TELEPHONE	63	46	65	59	46	65	$343
EMPL BENEFITS	503	366	519	478	367	523	$2,756
PAYROLL TAXES	340	247	351	323	248	353	$1,861
TRAVEL	81	59	84	77	59	84	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	16	12	17	$91
OWNERS COMP	301	219	311	286	220	313	$1,650
INS-PROP,LIAB,WC	32	23	33	30	23	33	$174
DEPRECIATION	139	101	144	132	102	145	$763
RENT	318	231	328	302	231	330	$1,739
MAINTENANCE	51	37	53	49	37	53	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,170	$4,487	$6,365	$5,861	$4,498	$6,411	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,604	8,439	11,971	11,023	8,459	12,057	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,664	1,210	1,716	1,580	1,213	1,729	9,111
BLDG - PRIOR	1,228	893	1,267	1,166	895	1,276	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
SALARIES-ADMIN	$2,590	$1,859	$2,723	$2,381	$1,842	$2,850	$14,245
SALARIES-CLERIC	1,366	981	1,436	1,256	972	1,504	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	148	216	189	146	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	28	24	19	29	$145
SUPPLIES	103	74	108	94	73	113	$564
TELEPHONE	62	45	66	57	44	69	$343
EMPL BENEFITS	501	360	527	461	356	551	$2,756
PAYROLL TAXES	338	243	356	311	241	372	$1,861
TRAVEL	81	58	85	74	58	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	15	12	18	$91
OWNERS COMP	300	215	315	276	213	330	$1,650
INS-PROP,LIAB,WC	32	23	33	29	23	35	$174
DEPRECIATION	139	100	146	128	99	153	$763
RENT	316	227	332	291	225	348	$1,739
MAINTENANCE	51	37	53	47	36	56	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,144	$4,411	$6,460	$5,649	$4,369	$6,762	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,554	8,295	12,148	10,624	8,216	12,716	63,553
EQUIP - CURR	286	205	301	263	203	315	1,574
EQUIP - FULLY DEP	1,656	1,189	1,742	1,523	1,178	1,823	9,111
BLDG - PRIOR	1,223	878	1,285	1,124	869	1,346	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
SALARIES-ADMIN	$2,523	$1,972	$2,745	$2,372	$1,790	$2,844	$14,245
SALARIES-CLERIC	1,331	1,040	1,448	1,251	944	1,500	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	200	156	218	188	142	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	20	28	24	18	29	$145
SUPPLIES	100	78	109	94	71	113	$564
TELEPHONE	61	47	66	57	43	68	$343
EMPL BENEFITS	488	381	531	459	346	550	$2,756
PAYROLL TAXES	330	258	359	310	234	372	$1,861
TRAVEL	79	62	86	74	56	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	16	13	18	15	11	18	$91
OWNERS COMP	292	228	318	275	207	329	$1,650
INS-PROP,LIAB,WC	31	24	34	29	22	35	$174
DEPRECIATION	135	106	147	127	96	152	$763
RENT	308	241	335	290	219	347	$1,739
MAINTENANCE	50	39	54	47	35	56	$280
FEES & PUBLIC	4	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,985	$4,677	$6,511	$5,628	$4,247	$6,746	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,256	8,796	12,244	10,584	7,986	12,687	63,553
EQUIP - CURR	279	218	303	262	198	314	1,574
EQUIP - FULLY DEP	1,614	1,261	1,755	1,517	1,145	1,819	9,111
BLDG - PRIOR	1,191	931	1,296	1,120	845	1,343	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
SALARIES-ADMIN	$2,498	$1,884	$2,763	$2,328	$1,952	$2,820	$14,245
SALARIES-CLERIC	1,318	994	1,458	1,228	1,030	1,488	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	198	150	219	185	155	224	1,131
ACCOUNTING	8	6	9	7	6	9	45
WORK COMP INS	25	19	28	24	20	29	145
SUPPLIES	99	75	109	92	77	112	564
TELEPHONE	60	45	66	56	47	68	343
EMPL BENEFITS	483	365	534	450	378	546	2,756
PAYROLL TAXES	326	246	361	304	255	369	1,861
TRAVEL	78	59	86	73	61	88	445
IN SERVICE	4	3	4	3	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	15	13	18	91
OWNERS COMP	289	218	320	270	226	327	1,650
INS-PROP,LIAB,WC	31	23	34	28	24	34	174
DEPRECIATION	134	101	148	125	105	151	763
RENT	305	230	337	284	238	344	1,739
MAINTENANCE	49	37	54	46	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,926	$4,470	$6,554	$5,522	$4,631	$6,690	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,145	8,407	12,326	10,385	8,709	12,582	63,553
EQUIP - CURR	276	208	305	257	216	312	1,574
EQUIP - FULLY DEP	1,598	1,205	1,767	1,489	1,248	1,804	9,111
BLDG - PRIOR	1,179	890	1,304	1,099	922	1,331	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
SALARIES-ADMIN	$2,426	$1,839	$2,794	$2,432	$1,953	$2,802	$14,245
SALARIES-CLERIC	1,280	970	1,474	1,283	1,030	1,478	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	193	146	222	193	155	222	1,131
ACCOUNTING	8	6	9	8	6	9	45
WORK COMP INS	25	19	28	25	20	28	145
SUPPLIES	96	73	111	96	77	111	564
TELEPHONE	58	44	67	59	47	67	343
EMPL BENEFITS	469	356	540	470	378	542	2,756
PAYROLL TAXES	317	240	365	318	255	366	1,861
TRAVEL	76	57	87	76	61	88	445
IN SERVICE	4	3	4	4	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	16	13	18	91
OWNERS COMP	281	213	324	282	226	324	1,650
INS-PROP,LIAB,WC	30	22	34	30	24	34	174
DEPRECIATION	130	98	150	130	105	150	763
RENT	296	224	341	297	238	342	1,739
MAINTENANCE	48	36	55	48	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,756	$4,362	$6,627	$5,769	$4,634	$6,646	$33,794
FIXED ASSETS							
EQUIP - PRIOR	10,824	8,203	12,463	10,850	8,715	12,499	63,553
EQUIP - CURR	268	203	309	269	216	310	1,574
EQUIP - FULLY DEP	1,552	1,176	1,787	1,555	1,249	1,792	9,111
BLDG - PRIOR	1,145	868	1,319	1,148	922	1,323	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON PAGE 27

OCCUPIED DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,453	1,828	2,186	1,874	663	1,482	2,008	12,494
FEBRUAR	2,205	1,686	2,168	1,746	597	1,442	1,996	11,840
MARCH	2,383	1,773	2,434	1,904	604	1,569	2,285	12,952
APRIL	2,273	1,671	2,387	1,783	641	1,496	2,155	12,406
MAY	2,301	1,691	2,252	1,910	600	1,448	2,073	12,275
JUNE	2,211	1,730	2,175	1,793	603	1,426	1,906	11,844
JULY	2,317	1,823	2,396	1,846	652	1,459	1,889	12,382
AUGUST	2,249	1,817	2,342	1,861	673	1,516	1,966	12,424
SEPTEM	2,163	1,790	2,174	1,709	665	1,606	1,899	12,006
OCTOBER	2,249	1,815	2,246	1,709	627	1,766	1,986	12,398
NOVEMBE	2,288	1,675	2,189	1,590	594	1,689	2,002	12,027
DECEMBE	2,294	1,678	2,228	1,642	668	1,664	2,130	12,304
TOTAL	27,386	20,977	27,177	21,367	7,587	18,563	24,295	147,352
								147,352

OCCUPIED DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	15,318	11,446	16,069	11,449	3,078	11,405	16,083	84,848
								84,848

ALLOCATION PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
FEBRUARY	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
MARCH	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
APRIL	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
MAY	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
JUNE	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
JULY	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
AUGUST	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SEPTEMBER	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
OCTOBER	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
NOVEMBER	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
DECEMBER	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%

ALLOCATION PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%